State PBM Reform Inventory

Updated October 2026

Iowa

Issue	Summary	Citation
Licensing/Registration	A PBM doing business in this state shall obtain a certificate as a TPA under chapter 510, and the provisions relating to a TPA pursuant to chapter 510 shall apply to a PBM.	Iowa Code § 510B.2
Reporting Requirements	Each PBM shall provide a report annually by February 15 to the commissioner that contains all the following information regarding prescription drug benefits provided to covered people of each health carrier with whom the pharmacy manager has contracted during the prior calendar year: • The aggregate dollar amount of all rebates received by the PBM. • The aggregate dollar amount of all administrative fees received by the PBM. • The aggregate dollar amount of all health carrier administrative service fees received by the PBM. • The aggregate dollar amount of all rebates received by the PBM that the PBM did not pass through to the health carrier. • The aggregate amount of all administrative fees received by the PBM that the PBM did not pass through to the health carrier. • The aggregate retained rebate percentage. • Across all health carrier clients with whom the pharmacy manager was contracted, the highest and the lowest aggregate retained rebate percentages. A PBM shall submit a quarterly report to the commissioner of all drugs reimbursed at ten percent or more below the NADAC, and all drugs reimbursed at ten percent or more above the NADAC, for each prescription drug appearing on the NADAC list on the day the prescription drug was dispensed. A copy of the report shall be published on the PBM's public website for 24 months after the date the report is submitted to the commission. For each prescription drug included in the report, a PBM shall include all the following information:	Iowa Code § 510C.2; Iowa Code § 510B.8B

	• The month the prescription drug was dispensed. • The quantity of the prescription drug dispensed. • The amount the pharmacy was reimbursed. • If the dispensing pharmacy was an affiliate of the PBM. • If the prescription drug was dispensed pursuant to a government health plan. • The average national drug acquisition cost for the month the prescription drug was dispensed. • The report shall exclude 340B drugs.	
PBM Income	**Rebate Pass-Through:** All contracts executed, amended, adjusted, or renewed on or after July 1, 2025, that apply to prescription drug benefits on or after January 1, 2026, between a PBM and a third-party payor, or between a person and a third-party payor, shall include all the following requirements: • The PBM shall use pass-through pricing. • Payments received by a PBM for services provided by the PBM to a third-party payor or to a pharmacy shall be used or distributed pursuant to the PBM's contract with the third-party payor or with the pharmacy, or as otherwise required by law.	Iowa Code § 510B.8D
Pharmacy Contracting	**MAC Pricing:** Prior to placement of a particular prescription drug on an MAC list, a PBM shall ensure that all the following requirements are met: • The particular prescription drug must be listed as therapeutically and pharmaceutically equivalent in the most recent edition of the publication entitled "Approved Drug Products with Therapeutic Equivalence Evaluations", published by the FDA, otherwise known as the Orange Book. • The particular prescription drug must not be obsolete or temporarily unavailable. • The particular prescription drug must be available for purchase, without limitations, by all pharmacies in the state from a national or regional wholesale distributor that is licensed in the state. For each MAC list that a PBM uses in the state, the PBM shall do all the following: • Provide each pharmacy in a pharmacy network reasonable access to the MAC list to which the pharmacy is subject.	Iowa Code § 510B.8A; Iowa Code § 510B.8B; Iowa Code § 510B.8E

	• Update the MAC list within seven calendar days from the date of an increase of ten percent or more in the NADAC of a prescription drug on the list. • Update the MAC list within seven calendar days from the date of a change in the methodology, or a change in the value of a variable applied in the methodology, on which the MAC list is based. • Provide a reasonable process for each pharmacy in a pharmacy network to receive prompt notice of all changes to the MAC list to which the pharmacy is subject. **Minimum Reimbursement:** • A PBM shall not reimburse any pharmacy located in the state in an amount less than the amount that the PBM reimburses a PBM affiliate for dispensing the same prescription drug as dispensed by the pharmacy. • A PBM shall not reimburse any retail pharmacy located in the state in an amount less than the most recently published NADAC for a prescription drug on the date that the prescription drug is administered or dispensed. If the most recently published NADAC for the prescription drug is unavailable on the date that the prescription drug is administered or dispensed, a PBM shall not reimburse any retail pharmacy located in the state in an amount less than the WAC for the prescription drug on the date that the prescription drug is administered or dispensed. • In addition to the reimbursement required, a PBM shall reimburse the retail pharmacy or pharmacist a professional dispensing fee of $10.86. A PBM shall provide a reasonable process to allow a pharmacy to appeal any matter. The PBM shall allow a period of no less than 30 business days after the date of a pharmacy's initial submission of a clean claim during which the pharmacy may initiate an appeal. The PBM shall respond to an appeal within 7 business days after the date on which the PBM receives the appeal. • If the PBM grants a pharmacy appeal related to a reimbursement rate, the PBM shall do the following: ○ Adjust the reimbursement rate of the prescription drug that is the subject of the appeal and provide the NDC	

	number that the adjustment is based on to the appealing pharmacy. ○ Reverse and resubmit the claim that is the subject of the appeal. ○ Make the adjustment applicable to each pharmacy that is under common ownership with the pharmacy that submitted the appeal and each pharmacy in the state that demonstrates the inability to purchase the prescription drug for less than the established reimbursement rate. • If the PBM denies a pharmacy's appeal, the PBM shall do the following: ○ Provide the appealing pharmacy the NDC number and the name of a wholesale distributor licensed in the state from which the pharmacy can obtain the prescription drug at or below the reimbursement rate. ○ If the prescription drug identified by the NDC number provided by the PBM is not available below the pharmacy acquisition cost from the wholesale distributor from whom the pharmacy purchases the majority of its prescription drugs for resale, the PBM shall adjust the reimbursement rate above the appealing pharmacy's pharmacy acquisition cost, and reverse and resubmit each claim affected by the pharmacy's inability to procure the prescription drug at a cost that is equal to or less than the previously appealed reimbursement rate.	
Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** A covered person shall not be required to make a cost-sharing payment at the point of sale for a prescription drug in an amount that exceeds the total amount that the pharmacy at which the covered person fills the covered person's prescription drug order is reimbursed. A PBM shall not impose different cost-sharing or additional fees on a covered person based on the pharmacy at which the covered person fills a prescription drug order. **Copay Adjustment Programs:** A PBM shall include any amount paid by a covered person, or on behalf of a covered person, when calculating the covered	Iowa Code § 510B.8

	person's total contribution toward the covered person's cost-sharing. Any amount paid by a covered person for a prescription drug shall be applied to any deductible imposed on the covered person by the covered person's health benefit plan in accordance with the health benefit plan's coverage documents. For high-deductible health plans, these requirements only apply once a covered individual has met the minimum cost-sharing required to remain eligible for an HSA.	